MAP-26
Edition 5/03

Cabinet for Health Services
Department for Medicaid Services

PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM

To be placed on the Acquired Brain Injury Medicaid Waiver waiting list, an individual must first submit this application and a signed physician certification form. A copy of the physician certification form is enclosed for your use. Please mail the completed application and the signed physician's certification form to:

Brain Injury Services Branch
100 Fair Oaks Lane, 4E-D
Frankfort, Kentucky 40621

An individual will be placed in the waiting list in the order in which the application and the physician certification form are received in the office of the Brain Injury Services Branch. If the individual meets one of the following emergency criteria, he/she will be determined to have emergency status. Funding available will be allocated to individuals having emergency status prior to allocating funding to individuals having non-emergency status. The emergency status criteria are:

1. The individual is demonstrating behavior that places himself/herself, the caregiver, or others at risk of significant harm; OR

2. The recipient is demonstrating behavior which has resulted in arrest

If the individual is applying for emergency status, please provide detailed written information explaining his/her current circumstances. Additional sheets of paper may be used.

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For BISU Use Only:

Date received:	Time received:
Received by:	Date notice sent:

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Please provide the following personal information for the individual seeking services through the Medicaid waiver.

Name: _____ Medical Assistance #: _____

Mailing Address: _____

Date of Birth: _____ Telephone #: _____

Name of guardian (if applicable): _____

Address of guardian: _____

Guardian Telephone #: _____

Name of individual's caregiver (if applicable): _____

Address of caregiver: _____

Caregiver Telephone #: _____

Please answer the following questions.

1. Has the individual identified a case management provider to assist in securing and coordinating services once you are admitted to the ABI waiver program? ☐ Yes ☐ No

2. If yes, what is the name of the organization that will provide case management?

3. Does the individual currently demonstrate behavior that places himself/herself or a caregiver at risk of significant harm? ☐ Yes ☐ No

4. If yes, please attach a statement from a physician or other qualified mental health professional describing the nature and extent of the risk of harm involved.

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5. Has the individual been arrested? ☐ Yes ☐ No

6. If yes, please attach a statement from law enforcement or the court indicating when the type of offense(s) for which the individual has been arrested.

_____ _____
Signature of guardian Signature of applicant

_____ _____
Name of person completing application Relationship to applicant

_____
Telephone # of person completing application

Questions about individual referrals or the Medicaid Acquired Brain Injury Waiver program may be directed to the brain Injury Services Unit by calling, toll free, (800) 374-9146. Thank you.

KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY WAIVER
SERVICES PROGRAM
PHYSICIAN CERTIFICATION FORM

TO: _____

AGENCY: _____

ADDRESS: _____

_____ PHONE: _____

PHYSICIAN'S RECOMMENDATION

I recommend the Acquired Brain Injury Waiver Services Program for:

CLIENT: _____

ADDRESS: _____

_____ PHONE: _____

SOCIAL SECURITY #: _____ MAID #: _____

DIAGNOSIS (ES): _____

_____

I certify that if acquired brain injury waiver services were not available, nursing facility placement shall be appropriate for this individual in the near future.

PHYSICIAN'S NAME: _____ UPIN #: _____

ADDRESS: _____

_____

_____ _____
SIGNATURE DATE